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CONTENTS.

CLINICAL LECTURES.

On the Methods used in the Treatment of Fractures at the Pennsylvania Hospital. A Clinical Lecture delivered at the Pennsylvania Hospital, Nov 8, 1879. By Thomas G. Morton, M.D., One of the Surgical Staff of the Hospital. (Reported by Frank Woodbury, M.D.) . . . 177

HOSPITAL NOTES AND GLEANINGS.

Mr. Lister on Antiseptic Dressings . . 183
Wound of Right Internal Jugular Vein with a Fragment of Glass from an Exploded Lemonade Bottle; Copious Hemorrhage; Ligature; Persistent Contraction of Right Pupil; Remarks 184

MEDICAL NEWS.

Domestic Intelligence—Pilocarpine in Intermittent Fever 185
Virginia State Medical Society . . . 185
Jefferson Medical College 186
Change in the Curriculum of the Detroit Medical College 186
New Medical Journal 186
The Physician's Visiting List for 1880 . 188
Obituary Record 186
The late Mr. Callender 187
Foreign Intelligence—The Medical Uses of Milk 187
Balsam of Peru in Pruritus 188
Monstrosity 188
Carbolic Acid Poisoning 188
Death from Tetanus induced by a Hypodermic Injection 189
Nitrite of Amyl in the Night-Sweating of Phthisis 189
Martellement 190
A Fever Bed 190
Physiological Effects of Artificial Ischæmia 190
Accident with Paquelin's Thermo-Cautère 191
Colour-Blindness among Seamen . . 191

CHARCOT ON DISEASES OF THE NERVOUS SYSTEM . . . 12 PAGES

CLINICAL LECTURES.

ON THE METHODS USED IN THE TREATMENT OF FRACTURES AT THE PENNSYLVANIA HOSPITAL.

A Clinical Lecture delivered at the Pennsylvania Hospital, Nov. 8, 1879.

BY THOMAS G. MORTON, M.D.,
One of the Surgical Staff of the Hospital.

(Reported by Frank Woodbury, M.D.)

GENTLEMEN: My lecture this morning will be on the treatment of fractures of the long bones, with special reference to several methods which may be said to be peculiar to or which have originated in this institution. We have a right to express ourselves, I think, somewhat decidedly in regard to the treatment of fractures from the fact that a very large number of these injuries are annually received in this pre-eminently an accident hospital. Upon referring to the books, I find that since my connection with the hospital as surgeon we have had more than six thousand five hundred fractures under our care, and that during the past five years we have treated:—

COMPOUND FRACTURES—
86 of the cranium and face.
8 of the trunk and pelvis.
121 of the superior extremities.
213 of the inferior extremities.

SIMPLE FRACTURES—
85 of the cranium and face.
141 of the trunk and pelvis.
360 of the superior extremities.
711 of the inferior extremities.
19 cases of united fractures, and
31 crushes—the result of railroad injuries—make a total of 1725.

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This list does not include a very large number of fractures, more particularly of the smaller bones, which, after the first dressing, are turned over to the out-patient department. I refer to fractures involving the fingers and metacarpal bones, and not infrequently fractures of the forearm, and sometimes of the humerus, in the treatment of which admission to the wards was either not required or not desired by the patient.

In taking up the subject of the general treatment of fractures, we may now consider what is required upon the patient's admission. The fractured limb should never be roughly handled; all manipulations must be made with gentleness. If the patient is irritable or in pain, we use an anæsthetic; by this means we can clear up any doubt in the diagnosis; for then we can examine the part without any embarrassment from the sufferings or struggles of the patient. Should the injury be in the neighbourhood of a joint an anæsthetic is of the utmost assistance and occasionally indispensable. In examining the injury avoid all haste, proceed with deliberation, systematically and carefully; rough handling may not only injure nerves and bloodvessels, but provoke cellular inflammation. Should the parts require cleansing, it should be done at once before the fracture is dressed, so that there shall be as little disturbance afterwards as possible.

In considering the general principles in the treatment of fractures, there is one point which I wish to thoroughly impress upon the class as a cardinal rule, viz., *simplicity of apparatus and frequent inspection*. Some years since some new splints were brought to the hospital for trial, and presented to the late Dr. Norris, who was then one of the attending surgeons The chief recommendation for the apparatus was, that after the fracture was dressed, there was no need for the removal of the splint until the fracture was united, and Dr. Norris replied that this would be a grave objection to their use, as he made it a rule invariably to examine almost daily such cases in their progress towards a cure. Thus we object to the practice of "fixed dressings," so called in the early treatment of broken bones; later when the fracture is firm, the application of the silicate, starch, plaster of Paris, or binders' boards, comes in very well. The use of the latter is most frequent with us; the great advantage is, that binders' board can be cut, moulded in hot water, and neatly applied; after it has dried, a soft padding can be placed along the limb, and with a roller bandage as firm a dressing is obtained as is required; with this advantage, that it can be removed each day, the limb frictioned, all deformity removed, and every source of irritation prevented. It is not surprising that fractures should now and then be followed by no union, when from continuous tight fixed dressings the circulation is enfeebled. After the diagnosis of the fracture has been made, we then proceed to adjust the fragments, and bring them in apposition, and thus reduce the deformity. This is commonly called "setting the fracture," but even if it is possible at once to bring the broken ends of the bone in contact with each other, practically it is impossible to keep them so; thus the setting of a fracture is a process which requires often many days of careful manipulation and close attention. Take, for instance, an oblique fracture of the thigh; there will be more or less overlapping for some time in spite of our extension, so that we have to increase the extension, tire out the muscles, and mould the parts; this is only accomplished by daily "setting," or bringing the fracture in position. More or less swelling follows fracture as a result of the contusion of the adjacent soft parts; should the injury extend to the joint this is often very marked; therefore, we never apply a bandage upon a fracture until the œdema or swelling begins to subside; absorption has then carried off part of the exudation, and the firm pressure now of a well-applied bandage will aid the process. An immense amount of apparatus, often very complicated, has been devised for the treatment of fractures; much of it is perfectly worthless, and generally it is very costly.

After fractures have united, we use binders' boards, starch, silicate and occasionally the plaster-dressing, to keep the

limb absolutely at rest, not as fixed dressings. After these dressings have dried, they are cut down the front and back; this gives us two lateral well moulded splints, which can easily be taken off and are retained in position by a single roller.

The starch bandage was introduced in Europe by Suetin in 1834, and since then has been in general use. In application, it is convenient, readily obtained and clean; we often use it in this hospital after the union is moderately firm. The starch is prepared as it is for starching linen, and as each turn of the roller is made, a mass is rubbed on; two or three thicknesses of bandage will thus make a very firm dressing. In compound fractures we make an opening in the dressing after it has dried, so that discharges can readily escape.

The silicate of soda, like the starch, makes an eligible dressing.

The plaster of Paris we seldom use in the hospital; it possesses no advantages over the starch, silicate, or binders' board. Should you wish to use it, thoroughly dust finely-powdered plaster on the muslin as it is rolled into a bandage, then dip the roller into water, and, when it is saturated, it is taken out and smoothly applied, and with each successive turn the soft plaster is rubbed into all the folds of the bandage.

I will now call your attention to some of the more important fractures of the long bones, and present to you the main points in treatment, commencing with the upper extremity.

Fractures of the clavicle are treated in any number of ways, and the multiplicity of methods and apparatus shows conclusively that there is no one recognized plan. Dr. "Fox's apparatus," which is known all over the world, was introduced into this hospital by that surgeon in 1828; it forms a very effective dressing, and at once fulfils the indications in the treatment of the fracture by keeping the shoulder and arm upwards, outwards, and backwards. The apparatus consists of a wedge-shaped axillary pad, which is placed under the head of the humerus of the affected side; on the opposite shoulder is arranged a ring or collar, to which the pad is fastened by strings across the chest, back and front. The arm is now placed on the front of the patient's chest, and the elbow well supported by a strong muslin sling. There is no apparatus better than this for general use, as it allows the patient to attend to business, and gives excellent results; nevertheless, in many cases some deformity results, from the fact that the patient in moving about produces some jarring of the limb, and the bone becomes overlapped. In treating a broken clavicle in the female it is often very important that not the slightest deformity shall result, and we are obliged to take unusual precautions; we guard against deformity by adopting the "postural treatment;" the patient is placed upon the back on a moderately firm mattress with the shoulders kept horizontal, the head resting on a very thin pillow; the hand and forearm rest upon the chest or abdomen. This supine position is maintained until union is firm. We treat most of our clavicle fractures by this method, and we have no deformity resulting. This treatment was recommended by Hippocrates, and is as old as the hills.

Fractures of the sternum and scapula require only a brief mention, for we have nothing new to offer in connection with them; we mould the parts if much displaced, and then apply pads, a retaining bandage, with rest in bed, is all that will be needed as a rule.

Fractures of the ribs, unless complicated by wound of the lung or pleura readily recover with the simplest form of dressing. We partly encircle the chest with strips of adhesive plaster, two and a half inches wide; these strips are made to slightly overlap one another until a space of six or eight inches is covered; the patient is compelled to breathe with the diaphragm, which relieves the pain, by having the ribs at rest. All *fractures of the humerus* above the condyles, including the head and neck of the bone, are treated either with the anterior or internal angular splint; if with the latter, we use a moulded humeral binders' board splint; more commonly we bring the humerus to the side, close to the ribs, which act as the internal splint; a bandage is first ap-

plied from the hand to the shoulder, then the arm is bound to the chest, and a moulded shoulder cap of binders' board covers the acromion and humerus. In warm weather a light towel is placed in the axilla to absorb the perspiration and prevent irritation and excoriation. In fractures of the condyles we use either the anterior or internal angular splints. In order to avoid anchylosis we vary the splints and the angles almost every day, thus keeping up a certain change of position, and, as soon as repair begins to take place, we use passive motion daily.

In *fractures of one or both bones of the forearm* we use two straight splints: the one should go from the bend of the elbow to the finger ends, the other upon the opposite aspect of the arm, from the elbow to the wrist only; be careful that the epicondyle of the humerus is not pressed upon by the splint. In applying these splints we aim to preserve the motions of pronation and supination. In applying splints to the forearm we should have the thumb upward, so that the patient can look into the palm of his hand; in this position the radius and ulna are most widely separated.

Fracture of the olecranon process is treated by extreme extension, the arm and forearm being placed on a straight splint.

We recognize especially two *fractures at the lower end of the radius*; the one, "Colles's fracture," which is an inch or an inch and a half above the wrist, and "Barton's fracture," which extends obliquely from the articulation, backwards and upwards; thus separating more or less of the posterior articulating surface. The latter fracture has also been called the "silver fork" fracture, because the wrist has a peculiar curve which was thought to resemble a silver fork, produced by the fracture with deformity of the wrist. We use more commonly the old splint devised by the late Dr. Henry Bond, of this city, with excellent results, not only in the Barton, but in the Colles fractures. Within a short time Dr. Levis has introduced a splint which allows the hand to drop to a slight angle, the radius is thus thrown upwards. If, as is often the case, there is great deformity with the fracture, it must be reduced at once, using ether, if the parts do not yield to manipulation; after the reduction, small square pads, placed above and below the wrist with the bandage, will always keep the fracture in good position. The great advantage of the Bond splint consists in the unrestricted motion which is allowed the fingers, thus avoiding the partial consolidation of the tendons at the seat of fracture. Dr. Levis's splints are rights and lefts; they are of galvanized copper, moulded to fit the forearm, and, as already stated, they allow the hand to drop forward.

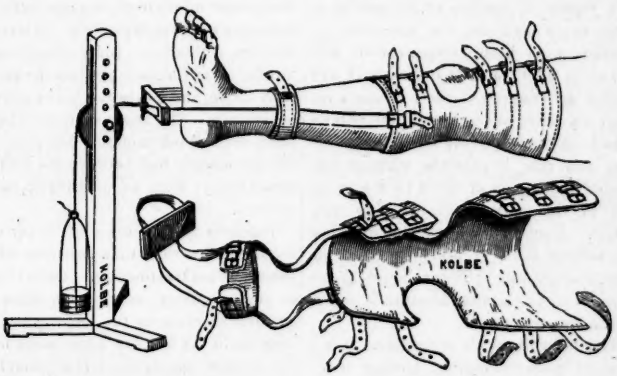
Fractures of the fingers are generally compound, and often comminuted, with more or less laceration of the soft parts; any portion of a finger saved is of immense value especially to the artisan. I would, therefore, urge upon you *never* to make a primary amputation of a finger be it ever so seriously injured, but wait until nature gives the indication for a secondary operation. You will thus save many a finger, which at the time of the injury seems hopeless, or, if required to be secondarily amputated, less loss of tissue will generally be required.

Fractures of the vertebral column and pelvis are simply kept at rest as far as possible, and the ordinary means employed to reduce deformity. The catheter is generally needed, and great attention to prevent bed-sores.

We now come to the treatment of *fracture of the femur*. The practice of making extension by lateral adhesive strips originated in this House. The apparatus is easily made and quickly applied. It is simply a 2½ or 3 inch adhesive strap, long enough to reach from just above the knee to the sole of the foot and up the other side to the same level, always taking care that the strips do not overlap the broken extremity. In the middle of this strap a piece of wood (2½ × 4 inches) is placed, which serves to keep the lateral straps from pressing on the malleoli, and to it the weights for extension are attached. Strips of plaster are also made to gird the limb above and below the knee, and above the ankle in order to prevent the apparatus from slipping. A roller band-

age is applied outside of the dressing from the foot to the hip, and sand-bags are placed one on each side of the limb to support it in good position. The lateral strips must not be allowed to go above the point of fracture, or the extension will be rendered useless; if they are applied tightly during swelling, when it subsides there will be wrinkles and folds that may cause ulceration. This dressing may slip during warm weather, and require re-application; and in the case of a male adult, the leg must be shaved before the plaster is applied, or pain will be produced in removing it. These are trifling objections, however, and do not impair the usefulness of this simple method of treating fracture of the femur, which is constantly employed in our wards. The method of making extension deserves a word of description. You see here a wire crib, whose base is of the same size as the weights employed. Into this we drop as many pound weights as we wish; and in this way can regulate precisely, from day to day, the amount of extension; it is more easily managed than when extension is made by a brick or bag of salt, or sand.

I now show you another apparatus



for making extension in the treatment of fractured thigh. Most of us are a little partial to our own devices, and perhaps I like this the more because it is original. It is the same in principle as the preceding, and is made as follows: the circumference of the thigh and leg is taken, that of the former four or five inches above the knee, and the latter four inches below the joint; leather, buckskin or any stout material may be used, which is cut according to the measurements to encircle the limb between these two points; an opening is left for the patella; the portions of the apparatus above and below the knee should buckle or lace up above separately; on the outside of this a band of any stout material is buckled or sewed, it should be long enough to extend to the sole of the foot and up on the inner side of the limb to the knee, where it is fastened in like manner; just above the ankle a band encircles the limb, which keeps the extension strips in position. As the band passes around the sole it is attached to a piece of wood, the same as is used in the adhesive plaster extension, and sand bags complete the dressing. This apparatus is easily applied, and can be removed as often as desired, to wash or rub the limb; it does not interfere with circulation, and is very comfortable to the patient. This apparatus can be readily made by any one in a short time, or may be obtained from an instrument-maker by sending the girth of the limb above and below the knee, and its length; the apparatus can be used on either limb.

One point must not be forgotten. After applying the apparatus and the extending

weight, the foot of the bed should be elevated about four inches. Since the body will incline to the lowest point of the bed, this will give us a counter-extension. Unless the bed is elevated, the foot will soon be brought in contact with the pulley, and thus take off all the extension from the limb. The muscles, shortly after a fracture, become irritated, and spasmodically contracted, thus producing pain, and disturbing the fragments; but, in the course of a few days, by the lateral pressure of the sand bags and the steady extension this condition of the muscles is overcome, and the fractured ends of the bone can be placed in perfect apposition.

In regard to *fracture of the patella*, a great many methods, too numerous to mention, have been recommended; but just as in fracture of the clavicle, I will confine my remarks to those in use here. What we desire in fracture of the patella is to keep the fragments in close apposition, and this, if possible, without cutting off the supply of blood to the bone, and in this way not interfering with repair. Much of the apparatus used has the serious fault of pressing upon the bone, and allowing little or no nourishment to reach it; an ununited fracture is, therefore, a frequent result.

Here is Dr. Agnew's apparatus. It is a straight posterior splint, having cross-pieces above and below the knee, to which the bandage is attached. The roller is then applied from one side to the other, going first above the patella and next below it, in such a way as to bring the bone into good position.

Of all the apparatus devised for the purpose, however, I maintain that the original Malgaigne's hooks answer the purpose most perfectly. I show you here a modification of these hooks, which Dr. Levis made a few years ago by separating the set into two pairs, which act independently. Another arrangement for the same purpose, that I frequently use, is a set of four movable hooks, two for the upper fragment and two for the lower, which like the preceding are brought together by a long screw. Either of these can be applied in any position we desire, and give excellent results; it may be called the Pennsylvania Hospital modification of treating fractured patella. The first case in which I used the Malgaigne's hooks was that of Bridget S., who recovered with perfect osseous union; she came in the hospital with a recent transverse fracture of the patella, an interval of two inches existing between the fragments. After treatment, I presented her for examination before a number of surgeons, who were unable to detect which patella had been injured except by the little scars left by the hooks. Extension and flexion were perfect. When there is a comminuted or stellate fracture of the patella, union is often remarkably good, because the greater injury leads to more irritation and more callus is deposited. In a simple fracture of this bone, there often appears insufficient irritation to produce the desired bony union, and hence the hooks act very beneficially. The hooks should not be applied until all inflammation has subsided; this we usually find between the fifth and seventh day; with an anæsthetic pain is avoided.

Fractures of both bones of the leg often require more care than fractures of the femur, whose treatment, as you have seen, is comparatively easy. To allow the greatest freedom to the patient, and sitting up in the bed, we often make use of the anterior splint, which is also employed by some surgeons in the treatment of fracture of the thigh. But the treatment of fracture of the leg for which this institution is best known is that by means of the fracture-box, made the length of the leg, with a permanent foot-piece and falling sides. When a patient with a recent fracture is admitted into the ward, his leg is enveloped in an evaporating anodyne lotion (generally lead-water and laudanum), and a small pillow is then placed in this fracture-box, upon which the limb rests. The foot is secured to the foot-piece, and two pieces of bandage are tied around the box to secure the sides from falling. This allows frequent inspection, and the change of dressings as often as desired, and when union has occurred we use lateral splints of binders' board. In compound fractures the box is sometimes filled with bran, it may then be swung, if

more comfortable to the patient, in the same manner as by the anterior splint.

This fracture-box has given excellent results, and has been in constant use for many years. It is applicable to all fractures of the leg and foot except one; this peculiar fracture is when both malleoli have been broken, with the tibia dislocated backwards, the posterior part of the tibia comes in contact with the tendo Achillis, in fact the backward tibio-tarsal luxation of Malgaigne; if the fracture-box is used the heel is apt to be pressed up, and the deformity is likely to recur; there is now in the wards an example of this form of fracture, which is treated by suspension.

For *fractures of the lower end of the fibula*, Dupuytren's splint, or either the starch, silicate, or pasteboard dressings may be judiciously used, cut into lateral splints as before described, and the patient is at once allowed to be up on crutches. *Fractures of the tarsus and metatarsus* need not detain us, for we merely adopt the ordinary methods in common use by all surgeons.

HOSPITAL NOTES AND GLEANINGS.

Mr. Lister on Antiseptic Dressings.—After examining several cases at King's College Hospital, Mr. LISTER made some remarks on the subject of the various dressings he used. He had found that carbolic acid very quickly went through gutta-percha tissue, less quickly through oil-silk, and less quickly still through oil-silk when covered with gum-copal. Therefore the "protective" he used for wounds was oil-silk prepared with gum-copal. That the dressing he placed above this was truly antiseptic he thought he could say was proved. When the dressings had been handed round it could be seen that after having been next wounds for three and four days there were no signs of putrefaction. If ordinary dressings had been used they would have been black and stinking under the same circumstances. There was a time when people did not believe in the existence of oxygen; and there were people who did not believe in the existence of septic germs; but he believed that their presence had been demonstrated, and that the germ theory was more and more becoming accepted. Carbolic acid had been found to be most effective in preventing septic action. It might be used in various ways. If added to water a comparatively weak solution could be made, but the carbolic acid was very easily given up, and, if tested by touching the tongue with it, a one-in-twenty solution would be found to be almost caustic. Again, if added to oil, it formed a comparatively bland and stable solution of one in eight, and if mixed with resin it combined in the proportion of one in five to form a still more stable compound. When he first found that carbolic acid united with resin, and noticed its apparent change of properties, he thought that there must be some chemical change in the acid; but experiment showed that it was only given off more slowly, while it retained all its properties. This is the form now in which he uses the acid as a dressing, impregnating ordinary gauze with it. In addition, four parts of paraffin are added to the mixture to prevent the gauze becoming too glutinous. The advantage of this preparation is that it does not irritate the skin by too strong action, but that it keeps giving off the carbolic acid slowly, and lasts for a long time. He always wets the first layer in a watery solution of carbolic acid in order to have the wound and drainage-tube quickly brought under the influence of the antiseptic. Usually about eight layers of gauze are necessary for ordinary dressings. The use of the outer layer of mackintosh is to prevent the discharges soaking directly outwards; it directs it over the whole surface of the gauze, and thus makes a great many layers unnecessary.

A man was then brought into the theatre with a large ulcer of the leg, which had been dressed the previous week with benzoic acid. This, Mr. Lister said, was an antiseptic dressing new to them at King's College. On examining the leg (which had been dressed three days previously) it was found that all the dressings were sweet, that the ulcer was presenting healthy granulations, and that its surface

was raised to a level with its edges. When last examined it had been unhealthy and excavated. Benzoic acid had proved here to be truly antiseptic. The ulcer was dressed by washing it carefully with a watery solution of benzoic acid, covering it with protective and lint saturated with benzoic acid, and bandaging in the usual way. Mr. Lister had heard of men using the spray for dressing such wounds, but the spray was only meant to be used to prevent septic matter entering a cavity, and was not at all necessary when dressing superficial wounds.—*Med. Times and Gaz.*, Nov. 1, 1879.

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Wound of Right Internal Jugular Vein with a Fragment of Glass from an Exploded Lemonade Bottle; Copious Hemorrhage; Ligature; Persistent Contraction of Right Pupil; Remarks.—Thomas P——, aged fourteen, was admitted to the Worcester Infirmary, under the care of Mr. THOMAS WALSH, on July 29th, 1878. He was employed in a soda-water manufactory, and while in the act of stooping to pick up some bottles, a man in passing dropped a bottle of lemonade, which burst, and one of the fragments struck the boy on the right side of the neck, causing a wound about two inches in length, beginning about an inch above the clavicle, close to the trachea, and passing obliquely upwards and outwards across the anterior edge of the sterno-mastoid muscle. The man picked the boy up, and, with great presence of mind, pressed firmly on the wound, holding as well as he could the edges together, and ran down to the infirmary with him.

When first seen the boy was not at all collapsed, though he had lost a considerable quantity of blood. Directly pressure was removed by the man withdrawing his hand, the blood, venous in character, gushed out in a large and continuous stream, though, not being able to see any bleeding-point, the house-surgeon *pro tempore*, Mr. Wilson, endeavoured with a pair of artery torsion forceps to catch hold of the divided ends of the vein (for it was clear the bleeding proceeded from the internal jugular vein), but after trying some time without success, and the boy getting faint from the excessive loss of blood, he seized hold of the edges of the wound and held them firmly together, thus effectually controlling the hemorrhage, and sent for Mr. Walsh. On the arrival of this gentleman the boy had somewhat rallied. The clot which had formed was removed, and the blood welled up most alarmingly. An attempt was made to control the bleeding by pressure above and below in order that search might be made for the bleeding ends, but the wound in the vein was so near the innominate that no pressure below controlled the bleeding in the slightest degree. The boy was then placed under chloroform, the wound enlarged, and then, after several ineffectual efforts to seize the bleeding ends, Mr Walsh pressed with his left forefinger behind the posterior edge of the sterno-mastoid muscle, and thus, as it were, exerted pressure from behind, and in some measure moderated the bleeding, which chiefly came from the lower or cardiac cut-end of the vein. He then fortunately seized both ends, and included them in one ligature. It was not, however, quite clear what had been included in the ligature, whether the descendens noni nerve, or even the par vagum, the chief aim being to save the boy from immediate death by bleeding, and any attempt at dissection was out of the question. The hemorrhage now ceased, and the wound was united by sutures and dressed in the usual way. He was put to bed with hot bottles to his feet, and in a short time he drank a little milk. At 11.30 P. M. the nurse thought he was dying, and called Mr. Walsh, who found him fast asleep, his respiration being only four per minute. He was awoke, when he said he was very comfortable, his respiration while awake being normal. In a few minutes he fell asleep again, when his respiration once more dropped to about four per minute, and was rather stertorous in character. In about an hour's time his respiration became normal.

On July 30th he was very drowsy all day, sleeping continually, though easily roused; temperature 101.5°. Next day he seemed much better.

On August 1st the temperature went up

to 102.1°, the pulse being 114 and the respiration 24. On the 2d the drowsiness had nearly passed off: the ligature came away, the wound looking sloughy; temperature 99.2°. Four days later (the 6th) the wound had almost healed, and for the first time the right pupil was noticed to be contracted and the left dilated. On the 11th the pupils became very nearly equal. On the 14th the pupil of the right eye again contracted; the wound was healed; he complained of pain in the left knee-joint, which was found to be swollen and inflamed; temperature 101°; a back-splint was applied. On the 17th the knee was perfectly well; temperature normal. On the 21st he was discharged quite well, but with the right pupil still contracted and insensible to light.

On October 28d he came to show himself. Said he was quite well, though he looked rather heavy and dull. The right pupil was still contracted and insensible to light, while the upper eyelid drooped a little. The vision of both eyes was perfect.

Remarks by Mr. Walsh.—I have thought this case worthy of publication—first, because of the extreme danger attending wounds of the internal jugular vein, for even if hemorrhage be arrested (and many cases are on record where the attempt has failed), unhealthy inflammation with all its dangers frequently supervenes. Mr. Bryant says "wounds of the internal jugular vein are probably more fatal than wounds of the carotid, and when near the cardiac end, in addition to the danger of hemorrhage, is added that of introduction of air into the heart." There is also secondary hemorrhage and pyæmia looming in the future as a probable complication. Secondly, I do not remember to have experienced so much difficulty before in seizing the bleeding vessel, the depth of the wound being considerable, and the space before enlargement contracted Thirdly, the after-symptoms were rather inexplicable. Why should his right pupil be contracted and remain so? His head symptoms, as denoted by his extreme drowsiness, his infrequent respiration, etc., might be accounted for by his exhaustion from the loss of blood. Then, again, his threatened attack of pyæmia of the knee, which passed off in a day or two. Could a filament of the sympathetic nerve have been included in the ligature, and, if so, would that account for the above symptoms? Of course, it is clear that neither the descendens noni nor the par vagum was injured, or more serious results would have followed.—*Lancet*, November 1, 1879.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Pilocarpine in Intermittent Fever.—Dr. Gaspard Griswold, House Physician to Bellevue Hospital, from a study of seven cases of intermittent fever treated by muriate of pilocarpine in one-fifth of a grain doses administered hypodermically, concludes:—

1st. That the muriate of pilocarpine, administered hypodermically, will promptly cut short the chill of malarial intermittent fever.

2d. That in a large proportion of cases so treated the paroxysm aborts, terminating in the sweat caused by the pilocarpine, there being no hot stage.

3d. That such abortion of a paroxysm is in itself sufficient to effect a cure in many cases.

4th. That such abortion of a paroxysm is a valuable adjuvant to treatment with quinine during the intervals.

5th. That a dose of pilocarpine sufficient to produce this effect acts gently, without causing exhausting diaphoresis or unpleasant ptyalism.

The promptness with which an adequate dose of pilocarpine interrupts a chill is suggestive of its possible efficacy in cases of pernicious intermittent fever, where prevention of the full development of a paroxysm is often of the first importance. —*Med. Record*, Aug. 16, 1879.

Virginia State Medical Society.—The annual meeting of this Society was convened at Alexandria, on October 21, Dr. L. S. Joynes, of Richmond, President, in the chair. The following officers were elected for the ensuing year: President, Henry Latham, M.D., of Lynchburg. Vice-Presidents, Drs. W. H. Bramlett, of Pulaski;

R. C. Powell, of Alexandria; G. K. Robinson, of Danville; W. P. McGuire, of Winchester; W. H. Daughtry, of Southampton, and C. C. Conway, of Culpepper. Secretary, Dr. Landon B. Edwards, of Richmond. The next meeting will be held at Danville.

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Jefferson Medical College.—The faculty have appointed Dr. Henry C. Chapman Demonstrator of Physiology in this school, and Professor of Physiology in the Pennsylvania Dental College, to complete the course of physiology left unfinished by the late Prof. J. Aitken Meigs.

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Change in the Curriculum of the Detroit Medical College.—We take pleasure in announcing that the Detroit Medical College has recorded itself in favour of the improved curriculum, and has made the necessary changes, viz., preliminary examination, and a three years' graded course, to take effect at and after the session of 1880–81.

—

New Medical Journal.—We have received the prospectus of a new quarterly, to be called "The Chemist and Neurologist," and to be under the editorial control of Dr. C. H. Hughes, of St. Louis. The scope of the Journal is defined by its title, and its editor has long been known as an earnest student of his specialty.

—

The Physician's Visiting List for 1880.—Messrs. Lindsay & Blakiston have issued their Visiting List for 1880. In addition to the usual matter it contains an explanation of the metric system and a very full posological table. The whole forms a most convenient pocket visiting list, and is worthy of the good opinion in which it has been held by the profession during the twenty-nine years of its publication.

—

Obituary Record.—In this city, on the 9th of November, aged 50 years, James Aitken Meigs, M.D., Professor of the Institutes of Medicine and Medical Jurisprudence in the Jefferson Medical College, Philadelphia.

Dr. Meigs was born in Philadelphia, on the 31st day of July, 1829, received his scholastic education in the public schools, and graduated in Medicine at the Jefferson Medical College in 1851. In 1859 he was appointed physician to the Philadelphia Hospital; in 1868 he was elected to the chair of Institutes in the Jefferson College, as the successor of the late Professor Robley Dunglison, and in the same year he was elected physician to the Pennsylvania Hospital. Dr. Meigs was deeply interested in natural history, and before his professional labours became all-engrossing, he was an active member of the Academy of Natural Sciences of Philadelphia. In 1857 he arranged, classified, and catalogued the extensive collection of human crania in the Academy; he was also the author of several important contributions to craniology.

Dr. Meigs was a successful practitioner, an earnest student, and an acceptable lecturer, and he endeared himself to his patients and his pupils by his many excellent qualities of heart and mind.

At a meeting of the Faculty of Jefferson Medical College, held November 10th, the following resolutions were adopted:—

Resolved, That the Faculty of Jefferson Medical College have learned with profound sorrow of the death of their friend and colleague, James Aitken Meigs, which occurred on the morning of the 9th instant.

The Faculty desire to express their keen sense of the great loss they have sustained. While bowing to the decrees of an all-wise Providence, they deeply mourn the removal, in the prime of life, of their beloved friend and associate.

Gifted with superior powers of mind, cultivated and matured by a life of study and research, and genial and kindly in his bearing, he won the admiration and confidence of all with whom he associated.

His clear and impressive manner in the lecture-room secured the attention and sympathy of his pupils, and rendered him eminently successful as the expounder of an extensive and difficult branch of medical science.

At all times cordially in sympathy with his colleagues and loyal to the interests of the school at large, the Faculty feel, that

while they have lost a judicious and helpful companion, the Jefferson Medical College, for whose success he laboured so faithfully, has been deprived of both an ornament and pillar of strength.

Resolved, That, realizing the unutterable sadness thus brought upon the venerable father of Dr. MEIGS, the Faculty desire to convey to him their sincerest sympathy and condolence.

The late Mr. Callender.—The following minute was read by Prof. S. D. GROSS at the meeting of the Philadelphia Academy of Surgery, held November 3d, and ordered to be spread upon the records of the Academy:—

"Since the last meeting of the Academy the melancholy news has been brought to us of the death of our friend, Mr. George W. Callender, of London, who, during his two late visits to Philadelphia—the last one only a few weeks ago—endeared himself to us by his many social qualities, his amiable and agreeable manners, his lofty character, his great professional intelligence, and his scientific attainments. It is sad to think that such a man, in the prime of life and in the full fruition of his renown as a representative surgeon of Great Britain, should be lost so soon to his family, his friends, and his profession. The circumstances under which he died were peculiarly distressing. It was hoped when he left us, on the 15th of October, that, ill as he was, he would be spared, at least, long enough to reach his home, to breathe out his life in the bosom of his family and in the presence of his friends, who loved and respected him so much for his many virtues. He died at mid-ocean in less than six days after he left our shores, in the presence of his two loving and loved daughters, the companions of his travels, to whom and to his other children we herewith tender our warmest sympathy, trusting that a good and merciful God, the Father of us all, may solace and comfort them in their deep affliction, occasioned by the loss of a parent so kind and good, of a surgeon so learned and accomplished, and of a citizen so pure and patriotic. Although Mr. Callender was not a member of our young Academy, all of us are familiar with his life and works, and it, therefore, affords us a melancholy satisfaction to pay this tribute to his memory and to his worth."

FOREIGN INTELLIGENCE.

The Medical Uses of Milk.—M. BIOT, in the *Revue Mensuelle de Médecine et de Chirurgie*, March, April, and May, 1879, gives a summary of the clinical facts scientifically observed at the Hôtel Dieu at Lyons on this subject. The deductions and conclusions drawn by M. Biot touching the nature of acute articular rheumatism and the efficacy of the milk-regimen in the course of this affection, are based on a number of analyses of urine made as completely as possible, since they give the amount of the total nitrogen, of the urates, of the total chlorides, and of the phosphoric and sulphuric acids. His theoretical and therapeutical views on the subject are thus summarized. The fever of acute rheumatism generally lasts two or three weeks, and consequently, either from the time it lasts or on account of the rise in temperature, causes an enormous consumption of blood-corpuscles, which produces profound anæmia in the patient. The fall of temperature is the best criterion of the cure, and coincides exactly and constantly with the disappearance of the pains. The tortures endured by patients suffering from articular rheumatism are in themselves alone of a violence and tenacity sufficient to induce the physician to endeavour to oppose to this disease a treatment which would unite the three qualities *citò*, *tutò*, *et jucundè*. The milk-diet seems capable of fulfilling this desideratum; it causes the temperature to fall rapidly below hyperpyrexia, and simultaneously assuages the pains in a period varying from three to eight days. The effects from these two points of view are more prompt and more powerful if the patient be submitted to the milk-regimen at the outset of the affection. This milk-regimen, without overcharging the stomach or raising the temperature, by its nutritive power and its facility of digestion, prevents in great measure that characteristic and generally troublesome anæmia left behind by attacks of rheuma-

tism. Besides these general effects, milk-diet has a special action on the urinary function, which is clearly indicated in rheumatism. Milk strongly favours the elimination of all the waste principles accumulated in the organism; its exclusive use causes both the quantity of urine excreted in twenty-four hours and the quantity of all the saline principles dissolved in this liquid to increase rapidly; density, on the contrary, experiences a proportionate decrease. The impetus given to the urinary function by a milk regimen allows a glimpse of the nature of rheumatism, its near and intimate causes. The analysis of urine seems to show that there is an accumulation of urates or uric acid in the organism of rheumatic sufferers, and that its diminution under the influence of milk is not one of the smallest benefits of this regimen.—*British Med. Journal*, Nov. 8, 1879.

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Balsam of Peru in Pruritus.—In a communication to the *Deutsche Med. Woch.*, No. 34, Dr. Auerbach, of Berlin, states that having, in common with so many other practitioners, found the balsam of Peru a most valuable remedy in itch, he has for some time past treated pruritus by the same substance, and with the greatest success. After the first rubbing in to the part affected great relief is obtained, and in a few days a cure results. He relates a very obstinate case, which, after resisting all kinds of treatment for years, was speedily cured by the balsam.—*Med. Times and Gaz.*, Nov. 8, 1879.

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Monstrosity.—A remarkable case of monstrosity is reported in the *Wiener Medicin. Presse*, 1879, No 9. The child had been born dead. The upper part of its body was single, the lower double. It had two faces on a skull, which was about thirteen centimetres wide. Both individuals were not equally well developed, the one being five centimetres shorter than the other (thirty five and thirty centimetres), and the external genital organs were absent. It had also a large bifid spine. There were four frontal and as many parietal bones, and two occipital bones. The spines were separate. Both breast-bones were united in one; at their lower end, there was an opening in the skin of the size of a palm, through which the intestines protruded. The corresponding parts of the cerebra were united; the cerebella were separate. The organs of the throat and thorax were double; the œsophagus was single; the stomach also; the intestines were double, but abnormally formed. A small intestine ran from the stomach into the pelvis of the smaller fœtus, where it developed into a cæcum furnished with a processus vermiformis which opened into a duct, from which the ileum of the normally developed fœtus sprang. This ileum ended in an anus in the larger individual.—*British Med. Journal*, Oct. 18, 1879.

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Carbolic Acid Poisoning.—The following curious case of poisoning by the application of carbolic acid to the skin is reported in the *Berliner Klinische Wochenschrift* for October 6th by Dr. HAUNHORST. During his residence as house-surgeon at the Lunatic Asylum of Ueckermünde, he was asked one night to see one of the nurses, who had not felt very well for several days. She was suffering from a commencing phlegmon on the right forearm. The limb was much swollen, red, and very tender to pressure. He applied pads of cotton-wool that had been soaked in carbolic acid to the arm, wrapped it up, and told the patient to go to bed. On returning to his room, Herr Haunhorst felt his fingers becoming numb, and began to suspect that the carbolic acid had been too strong. A few minutes later, he was summoned in haste to his patient. She had lost consciousness; threw herself about in bed; her face was flushed; the pupils were contracted; the pulse slow; she breathed with much difficulty. The dressing was immediately removed, and a fresh one applied, which had been soaked in a 3 per cent. solution of carbolic acid. In the course of an hour, the patient recovered consciousness, and told him that immediately after the dressing had been applied she had felt a violent pain in her arm, and lost consciousness. She complained of fatigue and frontal headache. No urine could be obtained. The corro-

sive effect of the acid showed itself on the arm in several circumscribed white spots, beneath which the skin was exposed. The arm was healed in a fortnight, and the phlegmon had not broken out. The mischief had been caused by a mistake of the druggist, who had dispensed a 15 per cent. solution, instead of a 3 per cent. one.—*British Med. Journal*, Oct. 18, 1879.

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Death from Tetanus induced by a Hypodermic Injection.—An inquest was lately held by the coroner for the city of Dublin, on the body of a governess, aged about fifty-six years, whose death was attributed to the above cause. From the medical evidence adduced, it would appear that the deceased for years used to inject morphia herself subcutaneously, for the relief of neuralgia arising from bad teeth; and that the habit grew so upon her, that when suffering from this neuralgia her usual habit was to use twenty grains of morphia in the twenty-four hours. On the morning of the 10th ult., she had used twelve grains of morphia in one injection. Symptoms of tetanus showed themselves on the 12th, and were fully developed on the 14th. Dr. Austin Meldon, Surgeon to Jervis Street Hospital, who was called to see the patient, had her removed from her lodgings for convenience of treatment to his hospital. He was of opinion that the cause of the tetanus must have been the injury of some nerve by the needle in the self-administration of the injection on the 10th. From the 13th to the 17th, she was unable to swallow; but she recovered that power two days before her death on the 20th ult. Dr. Meldon deposed that the front of the body of the deceased was covered with innumerable scars from the punctures caused by the hypodermic needles; in fact, it was just as if she had been tattooed. He also stated that there was no case on record of such a large quantity of morphia ever having been used at a time as this lady had used. Two or three years ago, a case, he said, of death from tetanus produced by a wound from a subcutaneous injection occurred in London; but in that case, the dose was only two or three grains. He also knew of two other cases of lock-jaw produced in the same way. The jury found that the deceased died in consequence of traumatic tetanus supervening on a wound caused by the needle of a subcutaneous injection machine which deceased was in the habit of using, and that her death was the result of misadventure. This case is of much interest as bearing on the recognized possibility, as stated by Dr. Meldon, of the wound caused by a hypodermic injection inducing tetanus. We do not know of the particular case occurring in London alluded to by Dr. Meldon, or of the other cases he mentioned; but in the *Lancet* of July 6, 1867, three cases are referred to of death from traumatic tetanus after the hypodermic injections of sulphate of quinine; and in the same journal (December 16, 1876, p. 873), the case is reported of a lady who died at Southsea of well-marked tetanus after the use on herself of hypodermic injection of morphia, given, as it was supposed, with a rusty needle. With reference to this particular case, attention is directed to the symptoms resembling those of tetanus sometimes caused by morphia itself. In Dr. Meldon's case, however, this effect of morphia could not apparently have been in force, as he continued the injection of one grain of morphia when the patient was attacked with the tetanic spasms with instant relief to them.—*British Med. Journal*, Nov. 1, 1879.

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Nitrite of Amyl in the Night-Sweating of Phthisis.—Dr. WILLIAM MURRELL has recently made, at Dr. Ringer's suggestion, some observations on the influence of nitrite of amyl on the night-sweating of phthisis. The patients were seventeen in number, all adults—thirteen men and four women. All stages of the disease were represented; in some cases there was considerable elevation of temperature, whilst in others the lung mischief was latent. The majority of the patients were seen daily for some weeks, and some were under observation for three months. The medicine was given internally at bedtime, the dose varying from a half to three minims. For convenience of dispensing a one in ten solution in rectified spirit was usually employed, but in some cases the amyl was given in suspension in water or on sugar.

In three out of the seventeen cases no benefit was experienced from the treatment. These patients were all men. One had suffered from profuse perspiration all his life, not only at night, but also in the day-time, and he was covered with moisture on the slightest exertion even in the dead of winter. The amyl was given nightly in minim doses for a fortnight without checking the perspiration in the slightest degree. He had previously been treated unsuccessfully with oxide of zinc, hypodermic injections of atropia, and other drugs. On one occasion he was freely rubbed all over with belladonna liniment till his pupils were fully dilated, but the sweating continued as before. The second was a case of advanced phthisis, in which the amyl was given nightly for a fortnight in doses varying from one to three minims without benefit; oxide of zinc subsequently failed. In the third unsuccessful case the patient had hemiplegia and tertiary syphilis, in addition to his lung mischief. The amyl was taken in drop-doses for eight nights and seemed rather to increase than to diminish the amount of perspiration; in this case, too, oxide of zinc was given without benefit.

In the remaining fourteen cases the treatment was successful. The most striking case was that of a young man who had suffered severely from night-sweating for six weeks. A single dose of the amyl stopped them at once and completely for a fortnight. The perspirations then returned, and a single dose again kept them in check for a fortnight. For the third time this was tried, and with like result. It may have been a mere coincidence, but it certainly appeared to be the result of the treatment. In the majority of cases the treatment was less successful. Usually on the first night little or no benefit was experienced, on the next night the perspiration was less, and it gradually decreased in severity night by night till at the expiration of a fortnight it had nearly, if not wholly, ceased, and the patient was able to discontinue the medicine. At the expiration of about a week the perspiration would return, and it would be necessary to give the medicine again. One of these patients had renal disease in addition to the lung mischief, and another had frequent hæmoptysis. The others were simple cases of phthisis. Most of them were able to take outdoor exercise, but two or three were confined to bed.

Nitrite of amyl is a good remedy for night-sweats, but for promptness of action is decidedly inferior to atropia and other remedies.—*Practitioner*, August, 1879.

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Martellement.—The tribunals of the Seine Inférieure have recently been occupied with a curious case relating to the voluntary mutilations which young men practise upon themselves in order to escape the conscription. This operation is termed *martellement*, and consists in producing the deformity of one or more toes by causing a contraction of the flexors, the individual so operated upon walking on the ends of his toes instead of supporting himself on his plantar surface As the result of an inquiry that has been instituted, it appears that *martellement* has been practised in the locality for more than forty years, and that since 1839 all the conscripts, with the exception of three, have gained exemption. No information has been obtainable as to the mode in which the operation is performed. The young man who was accused, formerly a good walker, has of late seldom left the house, and for some months has ceased to appear at the village balls; and on examination it was found that he had recently undergone *martellement.*—*Med. Times and Gaz.*, Oct. 18, 1879, from *Méd. Rév.*, Oct. 11.

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A Fever Bed.—The Medical Officer of Health for Bristol, Dr. Davies, has reported an outbreak of typhoid fever in that city, distinctly traceable to contaminated milk supplied to the retailers from a Gloucestershire farm, where the water-supply came from a polluted well situate in the midst of manure in all stages of decomposition, the water itself throwing off large quantities of sulphuretted hydrogen gas. The surroundings, Dr. Davies states, were totally unfit for a dairy, and the water simply poisonous.—*Med. Times and Gaz.*, Oct. 18, 1879.

Physiological Effects of Artificial Ischæmia.—The effects, on the functions of the part, of the application of Esmarch's bandage to the upper limb have been investigated by S. Fubini, who has published the result of his researches in Moleschott's *Untersuchungen zur Naturlehre*, Band xii. He has arrived at the following conclusions, derived from observations made on a strong young man aged 20. 1. When the hand and forearm are brought into a state of bloodlessness by the application of Esmarch's bandage, the limb undergoes a diminution of volume, which, in the subject of the experiment, amounted to 62 cubic centimetres of water, at the temperature of 86° to 95° Fahr. 2. The ischæmia may last from 30 to 35 minutes, and exceptionally as long as 45 minutes. 3. The average loss of heat in the ischæmic part (hand and forearm) may be estimated at about 7 degrees Fahrenheit. 4. With the duration of the ischæmia, the temperature of the limb continues to fall; so that, at the end of twenty-five minutes, the reduction may be as much as 12.5° Fahr. On the other hand, there is a rise of about 2° and 3.5° Fahr. in the corresponding limb of the opposite side. After the cessation of the ischæmia, there is a fall of about 5.5° to 7° Fahr. in the temperature of the unbandaged arm; while the temperature of the limb that has been rendered ischæmic increases, and in about fifty minutes regains its original height. 5. The ischæmic limb rapidly loses its tactile sensibility and sensibility to pain. The power of perceiving differences of temperature disappears more slowly; indeed, the ischæmia cannot be continued long enough to produce complete insensibility to thermic irritants. 6. Tactile anæsthesia and analgesia appear more quickly in the peripheral than in the central parts of the ischæmic limb. 7. The muscular power, when tested by Regnier's dynamometer after the ischæmia had lasted twenty minutes, was found to be reduced to nearly one-half of its original value. 8. During ischæmia, the hand and forearm excrete less carbonic acid than under normal conditions, the proportion being 100 to 148.—*British Med. Journal*, Oct. 4, 1879.

Accident with Paquelin's Thermo-Cautère.—In the *Lyon Médical*, September 21, an account is given in which this instrument was employed for the purpose of cauterization in a case of diseased knee-joint. Ether was used as an anæsthetic, and the surgeons present were quite aware that accidents had before occurred from this taking fire. They were therefore on their guard, opening the window of the apartment (about sixty cubic metres in size), and keeping the vessel containing the ether at a distance from the cautery. The anæsthetization was tedious, so that 150 grammes had been employed, and a new bottle was just commenced with, when inflammation of the vapour in the room took place without any detonation, and the patient and doctors were enveloped in flame. Before this could be extinguished the patient was slightly and one of the doctors severely burned, and the bedclothes were set fire to. The patient never awoke, and the operation was terminated notwithstanding the accident. —*Med. Times and Gazette*, Oct. 4, 1879.

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Colour-Blindness among Seamen.—In January, 1877, the Board of Trade issued instructions to examiners for masters' and mates' certificates, directing that the candidates should be subjected to a test examination as to their ability to distinguish colours. A return issued yesterday shows that the number of candidates who failed to pass the test between May, 1877, and May, 1879, was 39. Of that number, however, 12 passed upon re-examination, and one was allowed to have passed without any further examination. In four cases the candidates were unable to distinguish colours, and in one case no particulars were given. Green was in twenty-five cases described as red, in five as yellow, in six as blue, and in five as other colours. Red was in twelve instances described as green, three times as blue, and once as another colour. Yellow was mistaken for green eight times, and for red eleven times. Blue was confounded once with green, once with red, once with yellow. Black was twice taken for green, and twice for red; and white was twice described as green.—*Edinburgh Med. Jour.*, Nov. 1879.

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INDEX TO VOL. XXXVII.

Abbot, viburnum prunifolium, 11
Abscesses, deep-seated, 49
Alabama State Medical Association, 74
Albuminuria, inhalation of oxygen in, 46
American Dermatological Association, 154
———— Gynecological Society, 154
———— Medical Association, 88
———— Neurological Association, 124
———— Ophthalmological Society, 138
———— Otological Society, 138
———— Public Health Association, 170
Amyl nitrite in night sweats of phthisis, 189
Anæmia, idiopathic, 17
Anæsthesia by protoxide of nitrogen under pressure, 107
———— from inhalation of iodoform, 140
Aneurism, aortic, treated by galvano-puncture, 24
————, popliteal, 133
————, thoracic, new treatment of, 107
Animation, suspended, 126
Antiseptic dressings, 183
Anuria, complete, with hysteria, 29
Ashhurst, on deep-seated abscesses and on periarthritis, 49
Astigmatism as a cause of headache, 81
Astragalus, reduction of old dislocation of, 151
Athetosis, 69
Audiometer, 143

Barwell, hematocele of neck, 135
Bastian, epileptiform neuralgia, 40
Baumgarten, organization of thrombus, 29
Bellevue Hospital Medical College, 106
Bigelow, Dr. Jacob, obituary notice of, 28
Billings, statistics of medical journals in United States, 26
Biot, medical use of milk, 187
Boston Medical Library Association, 11
Brain work, influence of, on growth of brain and skull, 108
Bride, centenarian, 63
Brinton, urethral stricture, 113
British Medical Association, 143
Broca, cerebral localization, 9
——, partial destruction of skull, 62
Bronchus, almond-shell in, 172
Brown-Séquard at Collége de France, 30
Browne, aortic aneurism treated by galvano-puncture, 24
Bullet, strange course of, 125

Calculus, large salivary, 107
————, magnesian intestinal, 157
California Medical Society, 105
Callender, obituary notice of Mr., 170, 187
Canada Medical Association, 175
Carbolic acid, poisoning by, 126, 188
————, use of, by midwives, 14
Carbonic acid, excretion of, in fevers, 14
Catalogue of Library of Surgeon-General's Office, Subject, 59
Catarrh, naso-pharyngeal, 145
Census of 1880, 60
Cerebral localization, 9
Cheilo-angioscopy, 109
Chicago Medical College, 95
Chloral poisoning, 165
Chloroform and chloral, 62
————, death from, 15, 46, 79, 126, 141
Climatology, 27
Clinical Lectures on—
Acute Infectious Diseases, 129
Astigmatism as a Cause for Persistent Headache and other Nervous Symptoms, 81
Diagnosis of Pregnancy, 3
Fractures of Skull, 97
Idiopathic Anæmia, 17
Injuries of Head, 65
Naso-pharyngeal Catarrh, 145
Ophthalmoscope in Diseases of Nervous System, 33
Prolapse of the Ovaries, 161
Treatment of Deep-seated Abscesses and on Periarthritis, 49
Treatment of Fractures, 177
Urethral Stricture, 113
Cohen, naso-pharyngeal catarrh, 145
College of Physicians and Surgeons, New York, 106
Colleges, American Medical, convention of, 60, 94
Colorado Medical Association, 124
Colour-blindness, 138, 159
———————— among seamen, 191
Congress, International Medical, at Amsterdam, 174

Connecticut Medical Society, 104
Conner, injuries of hand, 65
Contagious diseases, prevention of spread of, 74
Cousins, antiseptic ovariotomy, 120
Cupping, extemporaneous, 127
Cystitis, prevention of, after cantharides, 139
Cystoscope, 142

Davis, treatment of fibroids of uterus, 134
Death by drowning, signs of, 170
Dermatophony, 78
Detroit Medical College, 186
Diaphragm, laceration of, from distension of stomach, 46
Diphtheritic poison, 125
Directories, medical, 61
Disinfection, 137, 153
Drowning, signs of death by, 170
Dujardin-Beaumetz, oxygen inhalations in albuminuria, 46
Dysentery, salicylic acid enemata in, 62
Dyspepsia, 12

Eczema, acute, treated with jaborandi, 41
——— of leg, 54
——— of stumps, 125
Edis, laparo-elytrotomy, 38
Editors, Association of American Medical, 95
Electric light, 127
———, effects of, on vision, 157
Entozoa, subconjunctival, 171
Epistaxis, protracted, caused by parasite, 45

Fever bed, a, 190
Filters, new material for, 174
Fingers, dressmakers', 124
Flint, self-limitation of phthisis, 166
Fœtus, influence of medicinal agents on, 171
Food, diseased animal, 156
Forceps, use of, in labour, 110
Fractures, treatment of, 177
Fubini, physiological effects of artificial ischæmia, 191

Goodell, prolapse of ovaries, 161
Graduates in medicine, 60, 73
Gray, extra-uterine pregnancy simulating acute irritant poisoning, 150
Griswold, pilocarpine in intermittent fever, 185
Gross, Prof., complimentary dinner to, 74, 139

Hæmatocele of neck, 135
Hæmatoma of vulva, 71
Hammond, Ex-Surgeon General, 155
Hand, injuries of, 65
Harvard University, 61
Hays, Dr. Isaac, obituary notice of, 74
Head, involuntary rotation of, 55
Headache, astigmatism as a cause of, 81
Health legislation, public, 26, 59
———, National Board of, 72, 91
Heart, congenital affections of, 150
Heaton, involuntary rotation of head, 55
Homœopathy in Calcutta University, 15
Hueter, cheilo-angioscopy, 109
———, dermatophony, 78
Hunt, fractures of skull, 97
Hutchinson, idiopathic anæmia, 17
———, popliteal aneurism, 133
Hydrophobia, prize essay on, 30
Hysteria with complete anuria, 29

Illinois Medical Society, 105
Index medicus, 11
Infectious diseases, acute, 129
Iowa State Medical Society, 138
Ischæmia, artificial, physiological effects of, 191

Javal, coloured printing paper, 110
Jefferson Medical College, 61, 73, 186
Journals in United States, statistics of, 26
———, new medical, 45, 106, 186
Jugular vein, wound of, 184

Kinnear, action of sewer-gas on lead and zinc, 108
Klebs, sodium benzoate in infectious disease, 140

Landon, epistaxis caused by a parasite, 45
Laparo-elytrotomy, 38
Leared, dyspepsia, 12
Leyden, excretion of carbonic acid in fever, 14
Lichen planus, 55
Lister, antiseptic dressings, 183
Litholapaxy, 25
Lithotrity, rapid, 25
Louisiana Medical Society, 105
Lupus erythematosus, 54
——— vulgaris, 54

Macnamara, retinitis albuminurica, 42
Martellement, 190
Maryland Medico-Chirurgical Faculty, 105
Marine hospital service, 73
Massachusetts Medical Society, 123
Medulla oblongata, circumscribed lesion of, 158
Meigs, J. A., obituary notice of, 186
Michigan Medical Society, 124
Microphone, improved, 15
Milk, medical uses of, 187
Miner's Hospital, 155
Missouri Medical Association, 123
Monstrosity, 188
Montana Medical Association, 138
Morphia in oleic acid, topical application of, 59
Mortality statistics of United States, 104

Morton, treatment of fractures, 177
Murrell, nitrite of amyl in night-sweats of phthisis, 189
Myopia and colour of eyes, 174

Nerve-stretching in tetanus, 107
Neuralgia, simple epileptiform, 40
New Hampshire Medical Society, 123
New Jersey Medical Society, 104
New York Academy of Medicine, dedication of Library Hall, 169
———, Medical Society of State of, 45
Night-sweats of phthisis, nitrite of amyl in, 189
Noise, nuisance by, restrained, 159
Norris, ophthalmoscope in diseases of nervous system, 33
North Carolina Medical Society, 138

Obituary record, 28, 31, 62, 63, 74, 106, 111, 127, 143, 156, 159, 170, 175, 186
Ohio Medical College, 95
———— Society, 124
Ophthalmoscope in diseases of nervous system, 33
Ord, jaborandi in acute eczema, 41
Ovaries, prolapse of, 161
Ovariotomy, antiseptic, in a syphilitic, 120
————, Koeberlé's cases of, 126
Oxygen inhalations in albuminuria, 46

Packard, avoidance of scars after incisions, 26
Papaw, unripe, a digestive, 63
Paper, tinted printing, 110
Paralysis increasing among women, 15
Parvin, diagnosis of pregnancy, 3
Peabody donation fund, 63
Peaslee, foreign tribute to, 47
Pennsylvania Medical Society, 104
Periarthritis, 49
Pericardium, paracentesis of, 59
Personal, 15, 106, 175
Pharmacists, female, in Holland, 31
Pharmacopœia, convention for revising, 73
Philadelphia College of Pharmacy, 73
Philipson, pyelitis from calculus in ureter, 9
Phthisis ab hæmoptoë, 13
———, self-limitation of, 166
Physician's Visiting List, 186
Pilocarpine in intermittent fever, 185
Pityriasis versicolor, 55
Placenta, syphilitic affection of, 171
Pneumonia, treatment of, at Bellevue, 43
Poignard, tracheotomy in convalescence from typhoid, 12
Porrigo capitis, 55
Pregnancy, diagnosis of, 3
————, extra-uterine, simulating irritant poisoning, 150
Prize, Stevens triennial, 74
Pruritus, balsam of Peru in, 188
Psoriasis, 55
Public health legislation, 26
Pyelitis caused by a calculus in ureter, 9
Pyrogallic acid as an antiseptic, 79

Quinia, preparation of, soluble in water, 141

Retinitis albuminurica, 42
Rhode Island Medical Society, 123
Ringworm of scalp, 55
Royal Medical and Chirurgical Society, library of, 175
Rush Medical College, 61, 73

Sands, rapid lithotrity, 25
Sansom, congenital affections of the heart, 150
Scars, avoidance of, after incisions, 26
Scrofula, treatment of, 139
Serpiginous eruption, 55
Sewer-gas, action of, on lead and zinc, 108
Singing, influence of, upon health, 173
Skull, fracture of, 57, 97
———, partial destruction of, 62
Sodium benzoate in infectious diseases, 141
Sokolowski, phthisis ab hæmoptoë, 13
Spinal caries and curvature treated by paper brace, 152
Spleen, changes in volume of, 171
Staining microscopical specimens, improved method of, 30
Stevens triennial prize for 1882, 74
Stillé, resignation of Prof., 60
Stomach, temperature of, 173
Stricture, urethral, 113
Sturgis, athetosis, 69
Surgeon-General, United States Navy, 155
Suture, new elastic, 126
Sycosis, pustular, 54
Syphilis, propagation of, by toys, 78

Tarantulism, 111
Teeth, effect of smoking upon, 158
———, transplantation of, 46
Telephone and diseases of ear, 157
Tennessee Medical Society, 105
Tetanus induced by a hypodermic injection, 189
———, nerve-stretching in, 106
Thermo-cautery, accident with Paquelin's, 191
———————— for erectile tumours, 14
Thomson, astigmatism as a cause of headache and other nervous symptoms, 81
Thrombus, organization of, 29
Tooth, sudden death during extraction of, 157
Tracheotomy in convalescence of typhoid, 12
Trader, hæmatoma of vulva, 71
Tuberculosis, treatment of, 139

Ulcers, leg, 54
University of city of New York, 105

University of Maryland, 95
——— of Pennsylvania, 105
Uterine temperatures, 142
——— therapeutics, 142
Uterus, fibroids of, treatment of, 134

Vance, paper brace, 152
Verneuil, fracture of skull, 57
Viburnum prunifolium, 11
Vinet, hysteria with anuria, 29
Virginia State Medical Society, 185
Vomiting of pregnancy, arrest of, 156
Vulva, hæmatoma of, 71

Walsh, wound of jugular vein, 184
Warts treated by chromic acid, 29
Whittaker, acute infectious diseases, 129
Whooping-cough, statistics of, 125
Winckel's disease, 124
Wood, Dr. George B., obituary notice of, 76
Woodworth, Surgeon-General, obituary notice of, 62

Yale college, course of instruction in, 139
Yellow fever, disinfection for limiting spread of, 137
———, prevention of spread of, 122

INDEX.

ACHROMATOPSIA, hysterical, 192, 205, 229, 233
Acme, epileptic, 253
hystero-epileptic, 228, 255
Amblyopia, hysterical, 244
in disseminated sclerosis, 157
Amyotrophy, protopathic (see Atrophy, muscular)
symptomatic: in hysterical contracture, 245
of cerebral blood-clot (note), 43
of hemilateral lesion of the cord, 71
of disseminated sclerosis, 43, 164
of lateral sclerosis, 42
of posterior sclerosis, 42
Anæsthesia, its rôle in bed-sore of spinal origin, 66
Analgesia, 204, 208, 239
Angioneuroses, 92
of hysterical patients, 94
Apoplexy, spinal, 44
Arthritis, deformans, 81
Arthropathies of ataxic patients, 3
symptoms, 78
seat, 79
lesions of the joints, 80
alterations of cells of anterior cornua, 82
in progressive muscular atrophy, 83
of cerebral and spinal origin, 75
in traumatic hemiparaplegia, 69
of hemiplegic patients: historical sketch, 77
Arthropathies of hemeplegic patients—mode of invasion, 78
lesions, 79
clinical characters, 79
Articulations, trophic affections of, 17 (see Arthropathies)
Ataxia, locomotor, cutaneous affections in, 51
relation between these affections and fulgurant pains, 52
differences dividing ataxia from the tremor of disseminated sclerosis, 155
in disseminated sclerosis, 163
Atrophy, muscular, 3
consecutive on section of the ischiatic nerve, 7
arthropathies in, 83
progressive, 83
irritative lesions of nerve-cells in, 47
tendency to become generalized, 48
Attack, apoplectiform, in disseminated sclerosis, 168
its frequency, 167, 170
in general paralysis, 168
pathogenesis, 169
in cases of apoplectic foci of old standing, 169
varieties, 168
symptoms, 169
pulse and temperature, 170
Attaques-acces, 251 (see Seizure-fits)
Attraction (theory of), 99

Aura, hysterical, 192, 219
characters of, 219
first node, or ovarian pain, 219
second node, or globus hystericus, 219
third node, or cephalic phenomena, 220
influence of compression of the ovary on, 220, 223, 224, 227, 229, 230, 233, 252
Avant-mur (see Claustrum), 211

BED-SORE, 56, 94 (see Decubitus)
Bromide of camphor, 127
Bulbus rachidicus, muscular lesions consecutive on affections of, 48
lesions of, in paralysis agitans, 123
in disseminated sclerosis, 131, 169

CALABAR BEAN in paralysis agitans, 127
in disseminated sclerosis, 183
Capsule, internal, 211
Capsules, supra-renal, hemorrhage of, in spinal lesions, 86
Cells, nerve-, motor nerve-cells in anterior cornua of the gray substance of the cord, 41
lesions of these cells: acute form (infantile paralysis), 46
chronic form, progressive muscular atrophy, 47
rôle of motor nerve-cells in the production of trophic troubles, 49
yellow degeneration of, 143
lesions of, in disseminated sclerosis, 164, 165
in hysterical contracture, 245
Cerebrum, anatomical views concerning, 210
Chorda tympani, a dilator nerve, 95
Chorea, disorderly movements of, compared to tremor of disseminated sclerosis, 155 (see Hemichorea)
Cicatrices, vicious, 16
Cirrhosis of muscles, 37
Claustrum, 211
Cœlialgia, hysterical, 192, 218
Compression of the ovary, 224
its influence on hysterical seizure, 223
modus operandi, 224
historical sketch, 225
Congestion, apoplectiform and epileptiform, 255
Contractility, electrical, after pathological and after experimental nerve-lesions, 25
in hysterical contracture, 246
in fractures and luxations of the vertebral column, 44
in hæmatomyelia, 44
in acute central myelitis, 44
in disseminated sclerosis, 147 (see Myopathies)
Contracture, permanent hysterical, 192, 229, 230, 234
action of chloroform on, 235
convulsive tremulation in, 236
hemiplegic form, 234, 237
characters differentiating it from organic hemiplegia, 237
hemiparaplegic form, 234, 239, 242
prognosis, 245
sudden recovery in some cases, 242
reputedly miraculous cures, 242
incurable contractures, 243
lesions in, 244
pathological physiology of, 245
permanent, in sclerose en plaques (disseminated sclerosis), 164
tardy, in hemiplegia of cerebral origin, 78
of the ureters, 200
Convulsionnaires, 205, 226
demoniacs, 230
Convulsions (arrest of), in hysterical cases, by compression of the ovary, 224
in spinal epilepsy, 227

Corpora opto-striata, lesions of, their effects, 207
French theory, 209
British theory, 208
Currents, electrical, differences between continued and interrupted, 26 (see Faradization)
Crises, gastric, 175
Cutaneous diseases, 14, 15, 20, 63

DECUBITUS ACUTUS (acute bed-sore), 56
mode of evolution, 57
consecutive affections, 60
in apoplexy symptomatic of cerebral lesions in foci, 62
seat, 63
pathogeny, 64, 93
of spinal origin, 58, 64
seat, 64
in traumatic myelitis, 66
influence of position of spinal lesion, 67
in traumatic hemiparaplegia, 68
in spontaneous myelitis, 72
epoch of manifestation, 72
rôle of gray substance on its production, 73
influence of nerve-lesions on, 75
Degeneration, waxy, of the muscles, 38
Delire des grandeurs, ambitious delirium in disseminated sclerosis, 160
Diplopia in disseminated sclerosis, 157, 174
Dynamometer in paralysis agitans, 110, 118

ECCHYMOSES, visceral, in circumscribed cerebral lesions (endocardium, stomach, pleura, bladder), 85
of the epicranial aponeurosis, 85
in spinal lesions, 86
Electro-diagnosis, 23
Emboli, gangrenous, consecutive on acute bed-sore, 60
Encephalitis, 62
Endocarditis, ulcerous, with multiple emboli and typhoid state, 55
Epidemics, hysterical, 225
of St. Medard, 205, 226
of St. Louis, 242
Epilepsy, its relations with hysteria, 247, 249
description of a fit, 248
spinal, in hysterical contracture, 236, 245
in disseminated sclerosis, 166
its forms, 166
arrest of, 227, 252 (see Acme)
Eruptions, eczematous, 16
lichenoid and pustular, 51
pemphigoid, 16, 21, 75
Erythema pernio, 16
Eschar of nates, 3
of rapid formation, 56
its position in apoplexy, 62
in apoplectiform attacks, 169
sacral, 3
in locomotor ataxy, 53
in epileptic acme, 256 (see Decubitus)
Etat de mal, epileptic, 256
hystero-epileptique, 228, 252 (see Acme and Temperature)
Excitability, electrical (histological alterations corresponding to diminution of), 37
Experiments of Erb, Ziemssen, and O. Weiss, 36

FASCICULI, internal radicular, 54
irritation of, in posterior sclerosis, 54
Faradization and galvanization, difference of action, 26, 32, 37, 39
in disseminated sclerosis, 182
Foot (deformity of), in paralysis agitans, 116 (see Trepidation).
club, hysterical, 243, 246
Fulgurant pains, 53

GAIT, in paralysis agitans, 118
Ganglion, superior cervical (effects of its extirpation), 91

Glossy skin, 16
Griffe in a case of disseminated sclerosis, with lesion of the nerve-cells, 43
in paralysis agitans, 115

HANDS, deformities of, in paralysis agitans, 115
in rheumatism, 142
Hæmatomyelia, 44
pathogeny, 44
diminution or abolition of electrical contractility, 44
alteration of urine, 88
Hemianæsthesia, hysterical, 192, 202, 222
historical sketch, 204
lesions of special senses, 204
relations between hemianæsthesia, ovarian hyperæsthesia, paralysis, and contracture, 205, 222
characters which separate it from hemianæsthesia of cerebral origin, 207
of encephalic origin, historical sketch, 208
its characters, 208, 210
cases reported by Türck, 208 212
Hemichorea, 214
Hemiopia, 192
Hemiparaplegia, traumatic, 68
arthropathies in, 68
muscular atrophy in, 70
alteration of urine in, 87
Hemiplegia in apoplectiform attacks, 168
hysterical, 234
Herpes zoster (see Zona).
Histology, normal, of the nervous system, 133
Hyperæmia, neuro-paralytic, 85, 90
Hyperæsthesia, ovarian, 192, 202, 205
its frequency, 217
historical sketch, 217
clinical characters, 218
anatomical lesions of the ovary, 222
Hyperæsthesia, ovarian—
conclusion, 228
clinical cases, 229, 232, 251
Hysteria (see Contracture, Epidemics, Hemianæsthesia, Ovarian hyperæsthesia, Ischuria, Secours), epileptiform, 249
ovarian, 203
severe, 228
local, 217
Hystero-epilepsy, 223, 247
meaning of the term, 248
with distinct crises, 249
varieties of, 250
nature of, 252
temperature in, 253
epileptic acme, 257
severe cases of, 257

IMMOBILIZATION of members (effects of), 6, 10
Inco-ordination, motor, 155
Infection, purulent, sequela of bed-sore, 60
Intoxication, putrid, sequela of bed-sore, 60
Irritability, muscular, 25
Irritation (rôle of) of nerves in the production of trophic derangements, 14
Ischæmia, hysterical, 205
Ischuria, hysterical, 185
transient, 187
permanent, 187
historical sketch, 188
simulation, 189
differs from ischuria caused by calculus, 191
clinical case, 191
diagrams indicating amount of vomited matter and of urine, 194
chemical analyses, 195
remissions, 196
reality of, 197
comparative benignity of, 199
gravity of calcular ischuria, 198
mechanism of, 199

KIDNEYS (lesions of) consecutive on nerve-sections, 86
experimental contradictions, 13

LEPRA, anæsthetic, 21
Lesions, irritative, 8, 12
ocular, consecutive on irritation of the Gasserian ganglion, 10,12
on section of the trifacial nerve, 10
owing to spontaneous lesions of fifth nerve, 12
Lingual muscles, contractured, 232

MENINGITIS ascendans, simple purulent, or ichorous, consecutive on bed-sore, 61
chronic cervical, 20
of St. Medard, 205, 216
Medulla spinalis, effects of transverse section, 6, 13
Miracles of St. Louis, 242
Muscles, trophic or nutritive affections of, 22
in infantile paralysis, 49 (see Amyotrophy, Atrophy, Myopathy, Sclerosis, disseminated)
Myelitis, acute central, 44
diminution of electrical contractility in, 44
lesions of supra-renal capsules, 86
alterations of urine, 88
gastric crises, 175
partial amyotrophy, 43
spontaneous, 72
traumatic, 65
Myodynia, hysterical, 218
Myopathies consecutive on lesions of the spinal cord, 40

NEPHRO-CYSTITIS consecutive on spinal lesions, 86, 87
Nephrotomy, 187
gravity of, 198
Nerves, contusion and ligature of, 39
excision of, 39
patches of sclerosis on, 131
Nerves, dilator, 95 (see Chorda tympani)
facial (paralysis of), 25
glandular (irritation of), 100
ischiatic (result of section of), 6
secretor (researches of Ludwig on), 97
trifacial (result of section of), 7, 19
Samuel's experiments, 10, 102
spontaneous lesions, 11
trophic, 15, 101
origin of these nerves, 101
vaso-motor, 103
(rôle of) in reference to nutrition, 9, 14
irritation of, 94
Neuritis, 17, 18
trophic disorders connected with, 19
Neuroglia, 134
Nutrition (influence of the nervous system on), 3, 4, and passim
Nystagmus in disseminated sclerosis, 158

OBLITERATION of ureters by calculi, 190
duration, 191
gravity, 197
Oliguria, hysterical, 187
Osseous system (trophic affections of), 17
Ovarialgia, hysterical, 192, 205, 222
Ovary (position of), 220 (see Compression, Hyperæsthesia)

PARALYSIS agitans, 129
historical sketch, 108
nature, 109
general characteristics of, 109
modes of invasion, 111
symptoms, stationary period, 112
tremor, 112
attitude of body, 114
its value in diagnosis, 116
sine tremore, 117

Paralysis agitans—
painful sensations, 120
terminal stage, 122
terminations, 122, 123
pathological anatomy, 123
physiological anatomy, 124
causes, 124, 126
treatment, 126 (see Propulsion, Retropulsion, Utterance)
Paralysis, bulbar, symptomatic of disseminated sclerosis, 177
consecutive on nerve-lesions, 32
general progressive, characters which assimilate it to disseminated sclerosis, 150, 159 (see Apoplectiform attacks)
general spinal (adult), 48
its analogies and differences with infantile paralysis, 48
hysterical, 193, 240, and passim
infantile, 46
anatomical lesions, 46
labio-glosso-laryngeal, lesions of the motor cells, 48, 159
pseudo-hypertrophic, 32
rheumatic (state of the muscular contractility in), 27
Paraplegia, traumatic (alteration of urine in), 87 (see Hemiparaplegia)
Paresis of the lower extremities in disseminated sclerosis, 161
remissions, 162
Petit mal, epileptic, 252
Pharynx (paralysis of the), 232
Phlegmon (pseudo-), 16, 58
Preliminary remarks, 1
Propulsion in paralysis agitans, 110, 116, 119, 262
Pulse in apoplectiform attacks, 171
Putamen, 211

REMISSIONS, 112, 162
Retention of urine in hysterical cases, 187, 238, 232
Retropulsion in paralysis agitans, 110, 119, 262
Rigidity of the limbs and neck in paralysis agitans, 114 (see Contracture)

SALIVATION in paralysis agitans, 114
Scleroderma, 17
Sclerosis, fasciculated, 41
descending, 168
disseminated (en plaques), lesions of motor cells in, 41, 43
lesions of the bulbus in, 48, 131
and paralysis agitans, 123
historical sketch, 108
lateral, in hysteria, 243
posterior, complicating disseminated sclerosis, 163 (see Ataxia, locomotor)
macroscopic anatomy, 130
distribution of sclerosed patches in brain, 131
in spinal cord, 130
on the nerves, 131
aspect of sclerosed patches, 132
histology, 139
alteration of vessels in, 143
nature of the lesion, 144, 148
spinal form, 132, 178
cephalic or bulbar form, 132, 178
cerebro-spinal form, 151, 179
causes of error in diagnosis, 151
diplopia, 157
amblyopia, 157
cephalic symptoms, 157
nystagmus, 158
vertigo, 159
facies, 160
psychic symptoms, 160
state of lower extremities, 161
unusual symptoms, 162
ataxia, 163
muscular atrophy, 164
contracture of limbs, 165
spinal epilepsy, 165, 236
apoplectiform attacks, 168
periods, 172
remissions, 174
gastric crises, 175
intercurrent diseases, 176
bulbar paralysis, 177
duration, 179
pathological physiology, 179
cause, 181
influence of acute diseases, 181

Sclerosis—
prognosis, 182
treatment, 182
"Secours" (les) in relation to the convulsionnaires, 226
Sections of nerves, complete or incomplete, 15, 17, 24, 36, 144
Simulation in hysteria, 189
Spasm (see Contracture)
Speech (see Utterance)

TARANTISM, 230
Temperature (significance of decrease of, in cerebral apoplexy), 64
diminution of, accompanying irritant nerve-lesions, 93
dependent on irritation of the great sympathetic (cervical), 94
in paralysis agitans, 121
in apoplectiform attacks, 171
in hystero-epileptiform attacks, 253
in epileptiform acme, 254
in hystero-epileptiform acme, 258
Tongue (contracture of), 232
Thermo anæsthesia, 204
Tremor, in general, 105
difference as regards repose and movement, 106
varieties, 107
historical sketch, 108
in paralysis agitans, 112, 154
in disseminated sclerosis, 156
influence of movements, 154
characters distinguishing it from chorea, 155
motor inco-ordination, 156
Trepidation provoked, of the foot in hysteria, 239
in sclerosis of the lateral columns, 240
in disseminated sclerosis, 239
in descending sclerosis, 239 (note)
Trismus, 193
Trophic derangements, 3
differences distinguishing them from passive lesions, 6
consecutive on lesions of the peripheral nerves, 4
traumatic causes, 17
spontaneous lesions, 19
theoretical views, 89
vaso-motor theory, 90
attraction theory, 99
trophic-nerve theory, 101
Samuel's theory, 102
criticisms, 102
conclusions, 103
in disseminated sclerosis, 176
Tubercle of spinal cord, 76
Tympanites, 193, 238, 239

UREA in hysterical vomited matter; in alvine evacuations after nephrotomy; influence of pressure on its production, 187, 195, 197, 202
Ureters (spasmodic contracture of), (see Obliteration)
Urticaria in locomotor ataxy, 51
Utterance (modifications of) in paralysis agitans, 113
in disseminated sclerosis, 158

VERTIGO, in disseminated sclerosis, 159, 174
epileptic, 253
Vomiting, hysterical, 196, 198
uræmic, 187
of blood, 238

ZONA, 16, 19, 21
in locomotor ataxy, 52
dependent on partial lesions of encephalon, 54
with modifications of the derm, 75
local elevation of temperature, 93
Zoster, herpes (see Zona)